

## **SURGICAL CONNECTION APPARATUS AND METHODS**

### **FIELD OF THE INVENTION**

[0001] This invention relates to apparatus and methods for surgically joining structures. More particularly, the invention can involve anastomosing tubular structures and can be used, for example, in a proximal anastomosis.

### **BACKGROUND OF THE INVENTION**

[0002] The occlusion of the arteries can lead to insufficient blood flow resulting in discomfort and risks of angina and ischemia. Significant blockage of blood flow in the coronary artery can result in damage to the myocardial tissue or death of the patient. In most cases, occlusion of the artery results from progressive long term deposits of plaque along the artery wall. While such deposits may be concentrated and occlude the artery at a particular site, the deposits are most certainly present throughout the arteries and the vascular system.

[0003] Coronary artery bypass graft (CABG) surgery is a surgical procedure performed in severe cases of coronary blockages. CABG procedures involve anastomosing an artery to a vascular graft which restores the flow of blood by establishing another pathway around the occluded vasculature. During coronary artery bypass graft surgery, a vein or other conduit can be attached proximally to the patient's aorta. The other end is attached to the blocked artery, downstream from the obstruction, thus bypassing the coronary occlusion. CABG procedures can be done by placing the patient on a heart-lung machine and stopping the heart from beating or they can be done on a beating heart without a heart lung machine. One problem encountered in either CABG procedure is the need to perform the procedure, while simultaneously maintaining sufficient function of the patient's circulatory system.

[0004] In the case where a CABG procedure involves arresting the heart so that blood flow is diverted from the vessel to be anastomosed, the patient's blood circulation is maintained by a cardiopulmonary bypass (CPB). This bypass is accomplished by diverting the blood flow at selected arterial locations. The blood

is diverted to the bypass system for release of carbon dioxide and subsequent oxygenation. Then, the blood is returned to the patient via a pump. Examples of these procedures are found in U.S. Patents: 5,799,661 to Boyd, et al. which discloses a device and method for performing CABG surgery for multi-vessel coronary artery disease through port-access or closed-chest thoroscopic methods; and 5,452,733 to Sterman, et al. which discusses performing grafts with an efficacy equal to or greater than conventional open surgical bypass techniques.

[0005] Although the beating heart CABG procedure eliminates the need for CPB, it has required diverting blood flow for a proximal anastomosis, such as one which attaches graft material (e.g., a graft vessel) to the ascending aorta. To attach the graft to the aorta in a beating heart situation, surgeons have typically used a “side-biting clamp” that isolates the aortic region where the anastomosis will be performed. This allows the surgeon to create the anastomosis without the site being exposed to the high-pressure blood flow of the normal aorta.

[0006] Among the drawbacks associated with aortic clamping are an increased chance of trauma to the arteries caused by ligatures at the clamped site and the possible dislodging of plaque within the clamped vessel wall. As mentioned above, the arterial bypass may be required due to the deposits of plaque which have occluded the vessel. However, the plaque is typically present throughout the artery and is not limited to the occluded location. Clamping the artery creates a risk of plaque being released into the blood stream. This release of plaque has the potential of causing a stroke, occlusion of a smaller peripheral vessel, or other vascular trauma. In a beating heart procedure, full clamping (i.e., cross clamping) of the aorta for graft attachment at the proximal anastomosis is not feasible. Therefore a side biting clamp is used to clamp off only a portion of the cross-section of the aorta, where the proximal anastomosis is performed. This type of clamping procedure poses the same risks described above with regard to cross clamping, e.g., the risk of release of plaque and resultant cause of a stroke, occlusion of a smaller peripheral vessel, or other vascular trauma.

[0007] Other attempts to address the problem related to blood flow diversion include diverting the blood by placing a balloon catheter within the aorta, such as described in U.S. Patent No. 5,868,702 to Stevens, et al., for example. Drawbacks of using a balloon catheter in creating a seal to divert blood flow include the

possibility of disturbing plaque deposits and creating particles in the blood stream, the chance that the balloon catheter may move within the aorta disrupting the seal and resulting in blood loss, and trauma to aortic tissue caused by the pressure needed to create the seal.

[0008] There remains some concern in the surgical community that neurological defects and strokes are associated with the use of heart-lung machines, side-biting clamps, and balloon occlusion devices.

[0009] PCT Patent Application No. PCT/US98/10245, to Cardio Medical Solutions and to Nobles, et al., which published under Publication No. WO 98/52475, attempts to address problems associated with diverting blood flow. Nobles, et al. provides a method and device for creating an area of hemostasis within a blood vessel without interrupting the flow of blood through the vessel which eliminates the need to clamp the vessel. However, the Nobles, et al. device requires the withdrawal of the hemostasis device prior to obtaining a tight seal between the graft and vessel. Therefore, since the area of hemostasis is lost upon the retrieval of the hemostasis device, the artery is open and blood is lost until the sutures are tightened.

[0010] Yet another problem related to CABG procedures lies in the procedure of suturing the vessels to create a tight seal. To ensure the integrity and patency of the anastomosis, the graft and vessel to be joined thereto must be precisely aligned with respect to each other. If one of the tissues is affixed too close to its edge, the suture can tear through the tissue and impair both the tissue and the anastomosis. Another problem is that, even after proper alignment of the tissue, it is difficult and time consuming to pass the needle through the tissues, form the knot with the suture material, and ensure that the suture material does not become entangled. These difficulties are exacerbated by the small size of the artery and graft. Another factor contributing to the difficulty of the CABG procedure is the limited time available to complete the procedure. The surgeon must complete the graft in as little time possible due to the absence of blood flowing through the artery. If blood flow is not promptly restored, sometimes in as little as 30 minutes, the tissues the artery supplies may experience significant damage or necrosis. As mentioned above, surgeons are under pressure to reduce the cross-clamp time, yet, an incomplete suture may result in a leak in the tissue approximation between the vessel and graft.

Moreover, the tissue approximation must be smooth and open. Hence, the suture cannot be hastily performed.

[0011] Additionally, the difficulty of suturing a graft to an artery using minimally invasive surgical techniques, where the surgeon uses ports to access the internal organs to perform the procedure, has effectively prevented the safe use of complicated suturing technology in cardiovascular surgical procedures. Accordingly, many procedures are performed invasively and require a sternotomy, an opening of the sternum. As a result, the recovery times for patients is significantly increased. U.S. Patent 5,868,763 to Spence, et al. attempts to circumvent the suturing process by attaching the vessels to a cuff device. Spence, et al. utilizes a passageway for continued blood flow so there is no clamping of the artery.

[0012] Arcia, et al., in U.S. Patent No. 6,358,258, describes systems and methods for performing anastomosis or attachments of body ducts, which are asserted to simplify suture delivery in both stopped heart and beating heart procedures and to be suitable for use in a minimally invasive environment using percutaneous ports, or with retractor systems or in a generally open surgery environment. Bolduc, et al., in U.S. Patent No. 6,461,365, describes surgical clips and methods of tissue approximation and attachment which are asserted as being useful in open surgical procedures as well as endoscopic, laproscopic, thoracoscopic and other minimally-invasive procedures.

[0013] Houser, et al., in U.S. Patent No. 5,989,276, discloses various devices and techniques for performing bypass, one of which includes a device which can be intralumenally originated. Various other clamping arrangements are provided for securing a graft to a vessel without the use of sutures or other fasteners.

[0014] In PCT Application No. PCT/GB01/04666, to Anson Medical Limited and to Hopkinson, et al., and which published under Publication No. WO 02/34143, apparatus is described for carrying out an anastomosis by sealing an arteriotomy and connecting a graft to the artery with the seal in place (see the Abstract). The apparatus includes means for sealing the hole and means for locating the graft on the outside of the wall of the artery. Once the graft is completely connected, the seal can be removed from the artery through the bore of the graft. Means may be

provided for clamping the graft and seal in place while the graft is being connected to free both of the surgeon's hands for the connection operation.

[0015] The problems discussed above can be exacerbated in those cases where multiple attachments or multiple anastomosis procedures are required. In those cases where multiple bypass procedures are performed, the patient will naturally be subject to increased risks as multiple grafts must be sutured to perform the bypass. Therefore, there is a need to improve and simplify surgical connection procedures such as anastomosis procedures.

### SUMMARY OF THE INVENTION

[0016] The present invention involves improvements in surgical connection apparatus and methods. According to one embodiment of the invention, surgical connection apparatus comprises a support structure; a plurality clips (e.g., self-closing clips) releasably coupled to the support structure; and a plurality of barbs coupled to the support structure and being separate from the clips, which are ejectable from the support structure independently of the barbs. The barb and clip arrangement can improve clip positioning uniformity and/or graft or prosthesis attachment consistency and/or efficacy. It also may advantageously reduce procedure time.

[0017] The clips also can be arranged for simultaneous ejection from the support structure, which can further reduce procedure time and improve graft attachment consistency and/or efficacy.

[0018] According to another embodiment, surgical connection apparatus comprises a support structure forming a first plurality of paths and a second plurality of paths; a plurality of clips, each clip being slidably disposed in one path of the first plurality of paths; and a plurality of barbs, each slidably disposed in one path of the second plurality of paths.

[0019] According to another embodiment, surgical connection apparatus for connecting a first structure to a second structure comprises a support structure, a plurality of barbs coupled to the support structure, a plurality of clips slidably coupled to the support structure and unattached to the barbs; means for moving the barbs; and means for ejecting the clips from the support structure.

[0020] According to another embodiment, surgical connection apparatus for connecting a first structure to a second structure comprises a support structure, a plurality of barbs coupled to the support structure, a plurality of clips slidably coupled to the support structure and unattached to the barbs; and means for simultaneously ejecting the plurality of clips.

[0021] According to another embodiment, surgical connection apparatus for connecting a first structure to a second structure comprises a support structure, a plurality of barbs, each coupled to the support structure and having a distal end portion, a plurality of clips slidably coupled to the support structure, means for moving the barbs between a first position where the distal end portions are inside the support structure to a second position where the distal end portions extend from the support structure; and means for ejecting the clips from the support structure.

[0022] According to another embodiment, a method of performing an anastomosis comprises everting a tubular graft structure over a support structure and passing a plurality of barbs from the support structure into the graft to secure the graft to the support structure; introducing the everted portion of the tubular graft structure into an opening formed in a second tubular structure; and simultaneously passing a plurality of clips through the tubular graft structure and second tubular structure to secure the graft and second tubular structures together.

[0023] According to another embodiment, a method of surgically connecting structures in patient comprises placing a first structure on a support structure and passing a plurality of barbs from the support structure into the first structure to secure the first structure to the support structure; placing the support structure adjacent a second structure in a patient; and simultaneously passing a plurality of clips through the first and second structures to secure the first and second structures together.

[0024] The above is a brief description of some deficiencies in the prior art and advantages of the present invention. Other features, advantages, and embodiments of the invention will be apparent to those skilled in the art from the following description, accompanying drawings, wherein, for purposes of illustration only, specific forms of the invention are set forth in detail.

### BRIEF DESCRIPTION OF THE DRAWINGS

- [0025] FIG. 1A is a perspective view of an anastomosis device in accordance with the principles of the present invention and shown in a first state;
- [0026] FIG. 1B illustrates the embodiment of FIG. 1A in a second state;
- [0027] FIG. 2A is a partial longitudinal section of the device of FIG. 1A;
- [0028] FIG. 2B is a longitudinal section of a portion of the device shown in FIG. 2A;
- [0029] FIG. 3A shows the device of 1A with the clip actuator assembly position prior to clip deployment;
- [0030] FIG. 3B is a sectional view of a clip delivery tube of FIG. 3A prior to clip deployment;
- [0031] FIG. 4A shows the device of FIG. 1A with the clip actuator assembly manipulated to partially deploy a clip;
- [0032] FIG. 4B is a sectional view of a clip delivery tube of FIG. 4A with a clip partially deployed;
- [0033] FIG. 5A shows the device of FIG. 1A with the clip actuator assembly manipulated for full clip deployment;
- [0034] FIG. 5B is a sectional view of a clip delivery tube of FIG. 4A with a clip fully deployed;
- [0035] FIGS. 6A-D illustrate a distal end portion of one of the tube pairs of the device of FIG. 1A where FIG. 6A shows the distal end portion before barb or clip deployment, FIG. 6B shows the distal end portion with a barb deployed, FIG. 6C shows the distal end portion with a barb deployed and a clip partially deployed, and FIG. 6D shows the distal end portion with a barb deployed and the proximal end of the clip positioned for full deployment;
- [0036] FIG. 7A illustrates a graft everted over a tube pair and a barb extended to engage the graft;
- [0037] FIG. 7B illustrates the graft and barb combination of FIG. 7A positioned in a target structure with a clip extended or partially deployed to engage the graft and target structure;
- [0038] 7C illustrates full deployment of the clip illustrated in FIG. 7B and the barb removed;

- [0039] FIG. 8A illustrates a graft everted over the distal end portion of the device of FIG. 1A prior to placement in a vessel opening; and
- [0040] FIG. 8B illustrates a completed anastomosis and removal of the anastomosis device illustrated in FIG. 1A.

### DETAILED DESCRIPTION OF THE INVENTION

- [0041] Before the present invention is described, it is to be understood that this invention is not limited to particular embodiments or examples described, as such may, of course, vary. Further, when referring to the drawings, like numerals indicate like elements.
- [0042] The devices, systems, and methods described herein generally can be used to surgically connect structures in a patient. They can be used to connect or anastomose tubular structures or conduits together. The tubular structures can be vascular or nonvascular structures. The illustrative embodiments will be described in connection with coronary artery bypass grafting procedures during which a vascular conduit or graft structure, such as a vein (e.g., a saphenous vein), artery (e.g., an internal mammary artery), or an artificial conduit or graft structure, is anastomosed to an aorta, the example target structure. It should be understood, however, that the invention can be used in other applications not specifically described herein. For example, the devices also can be used to anastomose internal mammary arteries to coronary arteries, and saphenous veins to coronary, femoral or popliteal arteries. As noted above, the devices described herein also can be used to connect other body lumens including nonvascular lumens, which can include, but are not intended to be limited to, the bile duct, the urethra, the urinary bladder, intestines, esophagus, stomach, and bowel.
- [0043] Referring to FIGS. 1A, one embodiment of surgical connection apparatus in accordance with the principles of the present invention is illustrated and generally designated with reference numeral 1300. In the illustrative example, apparatus 1300 is constructed for delivering piercing members or surgical clips 1310, which include ball shaped proximal ends 1311, sharp distal ends, and a loop shaped memory set shape or configuration (see e.g., FIGS. 3B, 5B and 6D), which although shown as an overlapping loop, can be non-overlapping or otherwise shaped differently than that shown. Accordingly, piercing member or clip 1310 is a self-

closing clip and can be nitinol wire and provided with the desired memory set configuration to exhibit pseudoelastic (superelastic) behavior. In other words, at least a portion of the shape memory alloy is converted from its austenitic phase to its martensitic phase when the wire is in its deformed configuration. As the stress is removed, the material undergoes a martensitic to austenitic conversion and springs back to its original undeformed configuration.

[0044] The shape memory alloy can be selected with a transformation temperature suitable for use with a stopped heart condition where cold cardioplegia has been injected for temporary paralysis of the heart tissue (e.g., temperatures as low as 8-10 degrees Celsius).

[0045] The cross-sectional diameter of the wire and length of the wire will vary depending on the specific application. The diameter of the wire may be, for example, between 0.001 and 0.015 inch. For coronary bypass applications, the diameter is preferably between 0.001 and 0.008 inch with a diameter of the wire loop in its closed configuration being between 0.0125 and 0.0875 inch. The wire may be formed in a loop shape by first wrapping the wire onto a mandrel and heat treating the wire at approximately 400-500 degrees Celsius for approximately 5 to 30 minutes. The wire is then air quenched at room temperature.

[0046] It is to be understood that the shape memory alloy may also be heat activated, or a combination of heat activation and pseudoelastic properties may be used as is well known by those skilled in the art.

[0047] Referring to FIGS. 1A and 1B, anastomosis device or apparatus 1300 generally includes a support structure for supporting the clips and can include an actuator for simultaneously deploying or ejecting the piercing members or clips. In the exemplary embodiment, the support structure comprises a plurality of piercing member or clip deploying or ejecting arms 1306, which form paths for the clips to move and be ejected therefrom. The arms can be tubular members and can comprise hypotubes. In the illustrative example, the support structure can further include barb supports, which also can be in the form of path forming arms. These arms also can be tubular members and can comprise hypotubes. As shown in the exemplary embodiment of FIGS. 1A and 1B, the arms are arranged to form a plurality of arm pairs, each arm pair including a clip carrying arm 1306 in which clip 1310 is slidably mounted or disposed and a barb carrying arm 1340 in which

barb 1342 is slidably mounted or disposed (FIGS. 6A-D). Although six arm pairs are shown, generally five to twelve arm pairs typically may be used depending on the application.

[0048] Arms 1306, which have an open distal end, and arms 1340, which have a rounded closed distal end, are arranged in spring body or spring support cylinder 1380 (FIG. 2A) so as to converge toward their distal ends as shown in FIG. 1A and 2A. A spreader or slide 1322, which can be generally in the form of a disc, can be used to radially expand the arm pairs from this configuration. One side of spreader or slide 1322 can be secured to shaft 1318, which can have a knob such as knob 1323 secured to a proximal end thereof. Spreader or slide 1322 has a plurality of circumferentially spaced longitudinal openings or grooves in which the barb-clip arm pairs are slidably disposed. As shown, each barb-clip arm pair is slidably disposed in a spreader opening or groove. When slide 1322 is in a proximal position as shown in FIG. 1A, arms 1306 and 1340 are in their converging configuration. As knob 1323 is moved distally, spreader or slide 1322 moves distally and expands arms 1306 and 1340 radially outward as shown in FIG. 1B.

[0049] Surgical connection or anastomosis device 1300 can include one or more mechanisms for deploying the barbs and/or clips. It can include an actuator assembly for simultaneously deploying the barbs and an actuator assembly for simultaneously deploying the clips. In the illustrative example, one actuator assembly for simultaneously deploying barbs includes an actuator knob 1350 and one actuator assembly for simultaneously deploying clips includes an actuator knob 1360. Body member or knob 1370 can be provided for the surgeon to hold while manipulating actuator knobs and a cover sleeve 1390, having a longitudinal slot 1392 formed therein, can be provided to cover the clip actuator assembly.

[0050] Referring to the illustrative example in FIG. 2A, the barb actuator assembly can generally include knob 1350, threaded member 1352, and cylinder or plunger 1354, which is secured or keyed to shaft 1318 to prevent relative rotation therebetween. Knob 1350 surrounds shaft 1318 and threaded member 1352 is fixedly secured to knob 1350. The threads on threaded member 1352 are configured to engage the inner threaded portion of knob 1370 so that knob 1370 can be maintained in a stationary position as member 1352 is rotated. Threaded member 1352 is coupled to cylinder 1354 to convert the rotational motion of

member 1352 to linear motion in cylinder or plunger 1354 so that cylinder 1354 moves distally or in an axial direction. One example mechanism is shown in FIG. 2B where threaded member 1352 has a flange 1353 at its distal end that is free to rotate in an annular groove formed in cylinder 1354. Retaining pins 1355 retain flange 1353 in the annular groove. As threaded member 1352 rotates and moves cylinder or plunger 1354 distally, cylinder 1354 pushes the proximal ends of barbs 1342, which are glued or otherwise secured thereto. This extends the distal ends of the barbs through windows 1344 and moves the distal ends of the barbs from a position inside arms 1340 to a position where they extend from arms 1340 (see e.g., FIGS. 6A and 6B).

[0051] The barbs or piercing members can be made from shape memory material such as nitinol and the distal ends of the barbs provided with a desired memory set shape such as the illustrated hook shape. Procedures similar to those described above can be used to set the shape. When the distal end of the barb exits tube 1340 and is no longer biased toward a generally straight configuration by tube 1340, it exhibits its pseudoelastic (superelastic) behavior and assumes its memory set hook shape as shown for example in FIG. 6B.

[0052] One embodiment of a clip deployment or ejection actuator assembly also is shown in FIG. 2A. In this embodiment, the clip deployment or ejection actuator assembly generally includes knob 1360 and cylinder or plunger 1366, which is secured or keyed to shaft 1318. Since shaft 1318 is fixedly secured to spreader 1322, shaft 1318 and cylinder 1366 are prevented from rotation relative to spreader 1322. Further, barb tubes 1340 extend longitudinally through cylinder or plunger 1366 and prevent cylinder or plunger 1366 from rotating relative thereto.

[0053] Cylinder 1366 is shown in partial section in FIG. 2A and includes a threaded outer surface 1368 that cooperates with threaded inner surface of knob 1360. These threaded portions are configured so that cylinder 1366 moves distally when knob 1360 is rotated in one direction. As cylinder 1366 moves distally, it pushes pusher arms 1324, which can be secured thereto. Each pusher arm can have an inner diameter less than the diameter of the ball shaped proximal end 1311 of a clip so that the pusher arms begin to eject or deploy clips 1310 (see e.g., FIGS. 4A, 4B and 6C).

[0054] The clip deployment actuator mechanism also can include a mechanism to retract the clip tubes 1306 when the clips are partially deployed and engaged with the target and/or graft structure. One embodiment of a mechanism to retract the clip tubes generally includes compression coil or spring support cylinder 1380, which includes a pin 1382 radially extending therefrom, coil spring 1384, which is coiled around cylinder 1380, and retaining plate 1386. In this embodiment, knob 1360 is provided with a circumferential opening 1362, which can extend less than or up to 360°, and a longitudinal opening 1364 extending therefrom. Spring 1384 is compressed between pin 1382 and plate 1386 when pin 1382 is not aligned with longitudinal opening 1364. However, spring 1384 is allowed to expand when pin 1382 is aligned with longitudinal opening 1364. In FIG. 2A, the pin is shown at the moment it is aligned with longitudinal opening 1364 and just prior to moving proximally therealong as spring 1384 is allowed to expand. Clip arms 1306 extend longitudinally through spring cylinder 1380 and are fixedly secured thereto by gluing, swaging or any other suitable means. In this manner, clip arms 1306 move with cylinder 1380. In contrast, barb arms 1340 are slidably disposed in longitudinal bores formed in spring cylinder 1380. Thus, when cylinder 1380 is retracted or moved proximally relative to spreader 1322, for example, the barb arms need not move therewith. The operation of the clip arm or tube mechanism is further illustrated in FIGS. 3-5.

[0055] Referring FIG. 3A, the clip actuator assembly position prior to clip deployment with pin 1382 spaced from longitudinal opening 1364 and compressing spring 1384 against plate 1386. Each clip is ready for deployment as shown in FIG. 3B with tubular arm 1306 restraining the self-closing clip 1310 in an open configuration or biasing the clip away from its memory set closed configuration. In FIG. 3B, clip 1310 is shown biased toward a generally straight configuration. After knob 1360 is partially rotated, clip 1310 is partially deployed and pin 1364 moves along opening 1362 toward longitudinal opening 1364 as shown in FIGS 4A and 4B. Knob 1360 is further rotated and pusher arms 1324 moved distally until pin 1382 is aligned with longitudinal opening 1364 at which time spring 1384 expands and pushes pin 1382 proximally as shown in FIG. 5A. Since clip arms 1306 are fixedly attached to spring cylinder 1380, arms 1306 move proximally with pin 1382 to release the proximal portions of clips 1310 from clip pushers 1324.

simultaneously. The deployed clips move toward or assume their memory shape set configuration, such as the loop shaped configuration shown in FIG. 5B. The mating threads on actuating knob 1360 and cylinder 1366 can be configured to facilitate deployment of all of the clips simultaneously upon one half turn of knob 1360.

[0056] Referring to FIGS. 6A-D, enlarged views of the distal portion of barb and clip arm pair is shown. FIG. 6A shows the distal portion of the arm pair before deployment of the barb or clip. FIGS. 6B shows barb deployment. FIG. 6C shows the barb deployed and a clip partially deployed. FIG. 6D shows the barb deployed and arm 1306 retracted to fully deploy clip 1310.

[0057] In use, a tubular graft is everted over the distal ends of the barb-clip arm pairs. Barb actuator knob 1350 is rotated to extend all of the barbs simultaneously through their respective openings 1344 (FIG. 6B) to secure the graft to anastomosis device 1300 (see e.g., FIGS. 7A and 8A).

[0058] If the distal anastomosis (i.e., the anastomosis between the other end of the tubular graft structure "G" and a target coronary artery) has not yet been performed, then a cross-clamp is placed on the free end portion of the tubular graft structure to prevent blood leaking from the tubular graft structure.

[0059] Once this is completed the surgeon forms an opening "O" (FIG. 8A) in the aorta using, for example, a scalpel and an aorta cutting device such as an aortic punch (not shown). It should be understood that other known devices to form the opening also can be used. For example, a cylindrical member with a sharp cutting cylindrical edge with a piercing member positioned therein with an arrow type head to catch the cut tissue can be used. When the aortotomy or opening has been completed, the surgeon removes the cutter or punch and introduces the anastomosis device. More specifically, the anastomosis device is then positioned in an opening formed in a target tubular structure (e.g., an aorta) to which the tubular graft is to be anastomosed. The barbs sit on top of the target structure (e.g., around the opening formed in the aorta) and serve as a stop for the device. Spreader 1322 can be moved distally to expand the arms and form a seal between the tubular graft and the target structure. If the distal anastomosis was previously completed, blood can flow through the everted tubular graft structure to the coronary artery, thus revascularizing the heart.

[0060] Actuator knob 1360 is then rotated to begin deployment of the clips, which begin to return to their unconstrained closed shape or configuration (FIGS. 6C and 7B). FIG. 6D shows a further step in clip 1310 deployment. Knob 1360 is further rotated until pin 1382 is aligned with longitudinal opening 1364 at which time spring 1384 is allowed to expand toward its relaxed state and move pin 1364 proximally and clip tubes 1306 therewith. This exposes the proximal portions of clips 1310 and allows the clips, including their ball portions 1311, to pass through the openings or slots in pusher arms 1324 (FIG. 6D). Once deployed, released or ejected from arms 1306, self-closing clips 1310 return or move toward their memory set closed shape or configuration as described above and depicted in FIGS. 7C and 8B. At this point, knob 1350 is turned or rotated the other direction to retract barbs back into the barb arms 1340 so that the entire device can be removed from graft and target structure (e.g., an aorta) as shown in FIG. 8B.

[0061] As noted above, the devices described herein generally can be used to surgically connect structures in a patient. In a further example, they can be used to connect a generally circular object, such as a valve prosthesis, to an anatomic structure, such as a valve annulus. In the valve case, the barbs are passed through the outer annular portion or the sewing cuff of a valve prosthesis instead of an everted graft. The barb-valve prosthesis combination is then introduced through the space inside a patient's valve annulus and the clips positioned for ejection beneath the valve annulus. The clips are then ejected in a manner to pass through the valve annulus and the valve prosthesis so that as they are ejected they move toward their memory set closed configuration and secure the valve prosthesis to the valve annulus. The barbs can then be retracted and the device removed.

[0062] Variations and modifications of the devices and methods disclosed herein will be readily apparent to persons skilled in the art. As such, it should be understood that the foregoing detailed description and the accompanying illustrations, are made for purposes of clarity and understanding, and are not intended to limit the scope of the invention, which is defined by the claims appended hereto.